Subject: Breast MRI (77058, 77059)		Original Effective Date: 12/13/17
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DISCLAIMER

This Molina Clinical Review (MCR) is intended to facilitate the Utilization Management process. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Molina) for a particular member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this Molina Clinical Review (MCR) document and provide the directive for all Medicare members.

DESCRIPTION OF PROCEDURE/SERVICE/PHARMACEUTICAL

MRI (Magnetic Resonance Imaging) is a non-X-ray (no ionizing radiation) imaging scan that uses a strong magnetic field and radiofrequency waves to produce detailed cross sectional views of soft tissues, bones and vascular structures. These cross sectional images can be reconstructed, rotated and displayed in many different planes. A MR scan can be performed either without (non-enhanced) or with (contrast enhanced) injection of gadolinium containing contrast material into a vein. Scans for evaluation of implants are performed without contrast only and scans for breast cancer are performed both with and without contrast. All scans should be done using a dedicated breast MRI surface coil.

APPROVAL SUPPORT

Breast Implants

- For suspected rupture of silicon (not saline) breast implants when mammography and breast ultrasound are indeterminate.
- Suspicious lesion in a patient who has had free silicone injected into breast.

Recent or known diagnosis of breast cancer

- New diagnosis of breast cancer
- To detect local recurrence in patients who have distorted breast tissue from surgery, biopsy, or radiation treatments which render mammography or ultrasound difficult to interpret.

- To determine tumor extent in a post-operative patient with positive tissue margins.
- For evaluation of a suspicious mass seen on mammography or ultrasound in a patient with a prior history of breast cancer if needle biopsy of that mass is inconclusive or cannot be performed.
- For pre-operative planning in a patient with known breast cancer.
- For evaluation of patients with a biopsy showing lobular carcinoma (LCIS) or atypical ductal or lobular hyperplasia.
- For detection of a primary breast cancer in a patient with axillary lymph node metastases if mammography and breast ultrasound are negative or inconclusive.
- For advanced breast cancer to assess response after neoadjuvant (preoperative) chemotherapy.

No prior history of breast cancer

- For evaluation of a suspicious lesion seen on imaging and biopsy could not be performed.
- Mammography was performed but was limited in diagnostic capability due to extremely dense breast tissue and breast ultrasound is inconclusive.
- Persistent reproducible single duct nipple discharge and mammography and ultrasound are inconclusive.

Annual Screening

- Greater than a 20% lifetime risk using a validated breast cancer risk assessment calculator (e.g. Gail, Claus, BRCAPRO, Tyer-Cuzik).
- History of extensive chest radiation prior to the age of 30. To begin no sooner than 10 years after treatment.
- Known BRCA carrier.
- First degree relative who has tested positive for BRCA gene and patient is untested. Encourage genetic testing prior to MRI.
- Personal history of or first-degree relative with Le-Fraumeni syndrome (TP53 mutation), Cowden syndrome (PTEN) or Bannayan-Riley-Ruvalcaba syndrome (BRRS).

ADDITIONAL CRITICAL INFORMATION

The above medical necessity recommendations are used to determine the best diagnostic study based on a patient's specific clinical circumstances. The recommendations were developed using evidence based studies and current accepted clinical practices. Medical necessity will be determined using a combination of these recommendations as well as the patient's individual clinical or social circumstances.

- Tests that will not change treatment plans should not be recommended.
- Same or similar tests recently completed need a specific reason for repeat imaging.

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	Description
77058	MRI (Magnetic Resonance Imaging) ONE BREAST
77059	MRI (Magnetic Resonance Imaging) BOTH BREASTS